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STATEMENT OF
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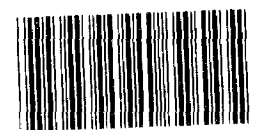
BEFORE THE
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
COMMITTEE ON LABOR AND HUMAN RESOURCES
U. S. SENATE
ON

EFFORTS TO REDUCE INFANT MORTALITY AND IMPROVE PREGNANCY OUTCOME



Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the issue of reducing infant mortality and improving pregnancy outcome.

During the past several years we have issued several reports which deal with various aspects of this subject. Today we would like to discuss the major steps we believe the Federal Government needs to take to enhance its efforts aimed at improving pregnancy outcome based on two of our more recent reports:

--One dealing with the barriers which hinder access to health care for low-income women and their babies (HRD-80-24, Jan. 21, 1980),

--One (accompanied by a staff study) which discusses obstetrical practices used during childbirth and some of the effects these practices have on pregnancy outcome (HRD 79-85, Sept. 24, 1979).

In our review of the barriers which hinder access to care, we evaluated Federal, State, and local efforts to reduce infant mortality by improving access to health care for low-income women and their offspring. Specific types of health care addressed included health education, family planning, prenatal and well baby care, labor and delivery services, and newborn intensive care. Our fieldwork was done in 15 counties and cities in

five states--California, Missouri, Mississippi, North Carolina, and Virginia--and the District of Columbia. Also, we obtained information by questionnaire from 49 States and the District of Columbia. Illinois did not respond.

Our evaluation of obstetrical practices was based on (1) a review of over 1,000 U.S. and foreign research articles on five obstetric practices--medication to relieve labor pain, elective induction of labor, preventive use of forceps and vacuum extraction, routine electronic fetal monitoring, and cesarean section; (2) a review of activities of several Federal health agencies; and (3) questionnaire responses from seven Professional Standards Review Organizations.

CONSIDERABLE PROGRESS HAS BEEN MADE

Our Nation has made substantial progress in improving pregnancy outcome. The Nation's infant mortality rate--which is the most frequently used indicator for measuring progress and is also one of the few universally used measures of health status--has declined from 29.2 in 1950 to 14.1 in 1977, the most recent year for which final national data are available. (Infant mortality is the death of a live born infant under 1 year and is usually expressed as a rate per 1,000 live births.)

The Federal Government has contributed significantly to this decline by helping to provide more and better health care for women and infants. This has been a national goal since 1935 with the enactment of the Maternal and Child Health (MCH) program. Since then the Federal Government has provided funds for:

--The construction of hospitals, including obstetrical and newborn care units.

--Training health care professionals, including obstetricians, pediatricians, and nurse-midwives, and providing health care professionals to deliver health services to persons living in many medically underserved areas.

--Research aimed at reducing infant mortality, preventing birth defects, and improving the quality of health care.

--A variety of formula grant, project grant, and health care financing programs to pay for the cost of health care and supplemental foods to meet the needs of many low-income, disadvantaged mothers and infants.

More recently, the Department of Health and Human Services (HHS) 1/ has:

- --Initiated a department-wide effort to better coordinate its health service delivery and health care financing programs.
- --Established a goal to reduce the Nation's infant mortality rate to 9 by 1990.
- --Identified areas in the Nation experiencing high infant mortality rates; awarded health service delivery project grants to and placed federally salaried health professionals in many of these areas; developed a number of management initiatives, such as Improved Pregnancy Outcome, Improved Child Health, and Adolescent Health Services and Pregnancy Prevention, to address this problem; and instituted efforts to evaluate State MCH programs--an activity which had not been performed for several years--and to improve problems identified.

1/Prior to May 4, 1980, this was the Department of Health, Education, and Welfare.

MUCH MORE REMAINS TO BE DONE

Despite the progress that has been made, many problems persist.

--Many areas of the country continue to experience excessively high infant mortality rates. In November 1978, HHS identified 564 such areas.

--The infant mortality rate for nonwhites (21.7 in 1977) is substantially higher than the rate for whites (12.3 in 1977).

--The percentage of all infants born alive with low birth weight (2,500 grams or less) has not changed significantly since 1950, while the percentage of nonwhite infants born alive with low birth weights was higher in 1977 (11.9) than in 1950 (10.2). Low birth weight is associated with nearly two-thirds of all infant deaths.

--More than 30,000 fetal deaths occur annually, and about 250,000 infants continue to be born with birth defects. More than one million induced abortions are performed annually.

ACTIONS NEEDED

Effecting further improvements in pregnancy outcome and strengthening Federal efforts in this area

are complicated, multifaceted problems that require a well-planned, well-designed and well-orchestrated approach. Our reports dealing with barriers to access to care and obstetrical practices contain over 40 recommendations to the Congress and HHS aimed at enhancing Federal efforts in these areas. While many actions are needed--some of which have already been initiated--we believe that the Government needs to act in the following eight major areas.

1. Develop a better planned, more systematic approach to the problems by taking such actions as

   --consolidating or better coordinating the variety of existing programs that are closely related, but have largely been established and administered independently of each other; and

   --strengthening the MCH program.

2. Expand Medicaid coverage to more low-income women, particularly during the prenatal period, and see that Medicaid payment rates are sufficient to enable eligible women and infants to gain better access to appropriate health care from the private sector. The Congress is considering legislation, such as

H.R. 4962 and amendment number 390 to S. 1204, which you proposed, Mr. Chairman, which would extend expanded Medicaid coverage to pregnant women and infants.

3. Improve efforts to prevent or favorably time high-risk pregnancies by
   --better coordinating federally funded family planning programs at the Federal, State, and local levels;
   --focusing more efforts on women--in addition to adolescents--who have or may have a high-risk for poor pregnancy outcome; and
   --accelerating efforts to resolve the many special problems that impede efforts to effectively prevent or delay adolescent pregnancies.

4. More aggressively promote and assist in efforts to develop and implement comprehensive, efficient systems of care for mothers and infants in local areas (commonly referred to as regionalized perinatal care). This can be done by
   --working with public and private organizations to see that regionalization efforts include prenatal as well as in-patient elements and

that the existence of duplicate public and private perinatal care "systems" is minimized;

--coordinating efforts between health planning and MCH efforts at all levels; and

--looking into the feasibility of using financial incentives or disincentives, through such programs as Medicaid or MCH, to encourage regionalization progress.

5. See that more State and local governments are granted cost reimbursement waivers for National Health Service Corps personnel used to improve pregnancy outcome in high infant mortality areas or take other action to get Corps personnel into areas needing them that have significant pregnancy outcome problems.

6. Facilitate, promote, and expand use of nurse-midwives (working in conjunction with obstetricians) to make maternity and other types of health care more readily accessible to low-income women. This should be done by

--providing additional funds for nurse-midwife training;

--working with State and local governments and professional organizations to

eliminate obstacles to using nurse-midwives, such as physician opposition, restrictive State licensing provisions, and lack of third-party payment coverage; and

--more aggressively encouraging and helping federally funded health care centers to use nurse-midwives.

7. Expand educational efforts, in conjunction with States and private organizations, for public awareness of the benefits and importance of preventing or favorably timing pregnancies that could or may be high-risk, seeking prenatal care early during pregnancy, and seeking periodic well-baby care for infants.

8. Ensure high quality perinatal care by

--sponsoring or promoting, in conjunction with interested private organizations, adequate research on the benefits and risks of medical practices used during childbirth;

--seeing that the quality of medical care provided during childbirth is appropriately evaluated, such as the timing of scheduled cesarean sections;

--seeing that women are informed during the prenatal period about current knowledge of the benefits and risks of obstetrical practices;

--strengthening some of the Food and Drug Administration's procedures for approving or monitoring the use of drugs during childbirth; and

--coordinating HHS activities relating to obstetrical procedures.

As you can see from the above list, there are many actions needed to enhance Federal efforts to help reduce infant mortality. We would like to highlight four of these areas: 1/

--The need for a more systematic approach to the problem by the Federal Government.

--The need for expanded Medicaid coverage for low-income pregnant women and more reasonable Medicaid physician reimbursement rates for maternity care.

--The need for improved efforts to prevent or favorably time high-risk pregnancies.

--The need to ensure that women receive high quality medical care during childbirth.

1/The other four areas are summarized in appendix I.

NEED FOR A BETTER PLANNED, MORE SYSTEMATIC APPROACH

The major problem we see at the Federal level is the lack of a coordinated, comprehensive national plan and approach for using available resources to help reduce infant mortality. Although Federal programs have significantly contributed to the progress that has been made, we believe that the time has come for the Administration and the Congress to take a hard look at the structure and management of Federal programs aimed at or affecting pregnancy outcome. Since establishing the MCH program in 1935, many other programs have been created that provide access to the same or related types of services or activities funded by MCH. These programs include, but are not limited to, Medicaid, Community Health Centers, National Health Services Corps, Family Planning, Health Planning, and the Special Supplemental Food Program for Women, Infants, and Children (WIC). For the most part, these programs have been administered independently and frequently without coordination with the MCH program at the Federal, State, or local levels.

Some of the consequences of this fragmentation are:

--Persons living in many areas do not have ready access to or have difficulty obtaining health or related services that can help improve

pregnancy outcome, while some areas have a variety of federally funded health care services.

--Pregnant women and infants in some areas receive supplemental food under the WIC program but do not receive health care services, and persons in other areas receive health care services but no supplemental foods even though WIC's authorizing legislation requires WIC and health care services to be linked.

--Efforts between the public and private health care sectors are often not coordinated or are duplicated.

--Health planning activities affecting mothers and infants are fragmented, not coordinated, or are duplicated.

Many programs, problems, and issues are associated with the way Federal programs affecting mothers and infants are structured and managed. However, we believe that the MCH program is the key to ensuring that a system of care for mothers and infants is developed and implemented.

MCH program has not met expectations

Historically, MCH funds have enabled States to extend health services to women, infants, and children in urban and rural areas and to improve the management and promotion of MCH activities. However, MCH funds have not been sufficient to enable States to extend services to all those in need or to extend services to the extent envisioned in authorizing legislation or program regulations. In addition, State MCH agencies have had only limited effectiveness in their intended role as a planner, coordinator, overseer, evaluator, or focal point for MCH activities.

Use of MCH funding needs reassessment

MCH authorizing legislation provides that States strive to extend services to improve pregnancy outcome for mothers and infants statewide. However, States have been unable to extend services to improve pregnancy outcome to all areas or to all women and infants in need. In addition to limited funding, other factors which have contributed to this situation are (1) the variety of activities that compete for use of MCH funds (in addition to those directed at improving pregnancy outcome) and (2) Federal requirements that States--

using MCH funds--continue to fund a series of activities referred to as the program of projects.

States must have a program of projects in each of five areas--maternity and infant care, infant intensive care, family planning, health services for children and youth, and dental health for children. Although States use a substantial portion--about 54 percent--of their Federal MCH formula grant funds for program of project activities, these projects serve relatively few communities. For example, 30 States report having only one maternity and infant care project and, in aggregate, States report that maternity and infant care projects serve only about 240 of the 3,100 counties in the Nation.

We believe that the Congress needs to reassess the way MCH funds are to be used, including the program of projects concept, in view of the other programs that have emerged. We believe that State MCH agencies should develop comprehensive plans for improving pregnancy outcome and using MCH funds. These plans should

--identify and prioritize unmet needs;

--identify available resources, and the ability or inability of these resources to meet unmet needs, including other Federal project grant programs; and

--describe how MCH funds will be used to fill gaps which cannot be met through other programs because of insufficient funds, lack of an area's eligibility for such programs, or other reasons.

In responding to our questionnaire, State MCH directors said that their highest priorities for using additional MCH funds to improve pregnancy outcome would be, in decreasing order of importance, (1) providing additional prenatal care, (2) preventing unplanned teenage pregnancy, (3) providing additional health education, (4) improving data collection and analysis, and (5) improving management of MCH activities.

MCH management needs improvement

MCH authorizing legislation and/or HHS regulations provide that State MCH agencies are to plan, coordinate, and promote maternal and infant care services and serve as a focal point for developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For the most part, State MCH agencies have not fulfilled their intended role as a focal point for improved management of MCH activities. For example, none of the States we visited had current, comprehensive, or action-oriented plans for reducing infant mortality. This has contributed to slow progress

in developing and implementing comprehensive statewide or regional systems of care for mothers and infants.

State MCH agencies in some cases have not served or have not been able to serve as a focal point for improving pregnancy outcome for several reasons. These include their failure to have assumed or been given this role in their States, their heavy emphasis on service delivery, and the little emphasis given to the MCH program by HHS for several years.

One of the major reasons State agencies have been unable to serve as a focal point is that HHS bypasses State MCH agencies and awards project grants directly to private organizations. State MCH agencies we visited usually had little or no information on or influence over project grants--such as for Community Health Centers--made by HHS directly to local organizations. We believe that it is unrealistic to expect State MCH agencies to plan, develop, or promote an integrated system of care for improving pregnancy outcome without some input into the planning, placement, and operation of such projects. HHS has agreed that this problem exists and is working toward resolving it.

EXPAND MEDICAID COVERAGE FOR LOW-INCOME WOMEN AND ENSURE REASONABLE PAYMENT RATES

Although Medicaid pays for maternity care for many low-income women, many others have difficulty obtaining such care, particularly prenatal care, because many States exclude women who are pregnant for the first time or who are members of intact families from eligibility for Medicaid or do not consider them eligible until they have their babies. For example, North Carolina did not cover prenatal care for women who were pregnant for the first time. In North Carolina there are more than 80,000 births annually, and the State's Medicaid program pays for about 4,400 routine deliveries each year. However, North Carolina pays for prenatal care for only about 1,300 of these 4,400 deliveries.

Departmental regulations (42 C.F.R. 447.204) require that State Medicaid payments be sufficient to enlist enough providers to ensure that services are available to eligible persons at least to the extent that they are available to the general population. However, many physicians refuse to accept Medicaid patients because of low reimbursement rates, paperwork requirements, payment delays, or for other reasons. Obstetrician refusal to accept Medicaid patients was a major problem in each of the States visited.

For example, the California Medicaid program generally paid physicians a flat rate of $300 for prenatal care, delivery, and postpartum care, which was substantially less than the average amount paid for these services by California Blue Shield. Only about 23 percent of California's obstetricians accepted Medicaid patients. In 1977, only three of Kern County's 20 obstetricians accepted Medicaid patients, and about one-third of the babies delivered at the Kern County Medical Center that year were delivered by hospital residents. The District of Columbia's Medicaid payment to an obstetrician for a normal delivery was about one-fourth the average rate paid by Washington Blue Shield for the same service.

PREVENTING OR FAVORABLY TIMING HIGH-RISK PREGNANCIES

Many women who have or might have a high-risk of having an adverse pregnancy outcome can be identified prior to their becoming pregnant. Examples include women who are too young or too old, women who have certain medical conditions or who have had previous problem pregnancies, or women who have had several previous births or a very recent birth.

Family planning programs have helped to prevent unwanted or unplanned pregnancies and to optimize the timing of desired pregnancies. However, many women likely to have "high-risk" pregnancies continue to have

unwanted, unplanned, or ill-timed pregnancies. Health authorities believe that many of these pregnancies, particularly among adolescents, can be prevented or better timed through more or better family planning and health education programs.

Despite their achievements, family planning programs must do much more before they can significantly improve pregnancy outcome. Significant numbers of unplanned births occur each year, indicating a lack of effective family planning. One prominent private organization in the family planning field estimates that nearly two-thirds of all adolescent pregnancies and half of all adolescent childbirths are unplanned. The National Center for Health Statistics estimates that there were nearly 544,000 births to unwed mothers in 1978. Health officials and others believe that most of these were unplanned. Additionally, in 1978, there were about 199,000 births to women of all ages which occurred less than 18 months after a previous birth. Health authorities consider a birth interval of less than 18 months to be a high-risk situation.

Another index of unplanned pregnancy--and, indirectly, the lack of effective family planning--is the number of abortions performed. In 1977, about 1.3 million women in the United States had induced abortions, with the

District of Columbia having more abortions than live births.

Family planning services are unavailable, inaccessible, or ineffectually used for several reasons, including lack of coordination among programs, lack of focus on high-risk women, limited resources, and problems, applicable particularly to adolescents.

HHS has recognized most of these problems and has taken action to help resolve them. However, HHS needs to take more aggressive and coordinated steps before it can have greater impact. Three areas needing attention are:

--Coordination among family planning programs.

--Emphasis on women who are or could have high risk for adverse pregnancy outcome.

--Aggressive action to help resolve problems relating to preventing adolescent pregnancies.

Family planning efforts often lack coordination at all levels

Family planning services are federally funded under several programs, including title X Family Planning, MCH, Medicaid and Social Services, and Community Health Centers. At the local level, many organizations provide such services, including local health departments, nonprofit organizations (e.g., Planned Parenthood), hospitals,

community health centers, and private physicians. Yet, in the areas we visited, no single organization planned, coordinated, or evaluated all subsidized family planning activities at the State or local level.

HHS contributes to the fragmentation and lack of coordination among family planning programs by (1) not coordinating its own programs, (2) failing to require an organization at the State and local levels to assume responsibility for overseeing the provision of subsidized services, and (3) awarding project grants directly to local private organizations, thus bypassing State health agencies. This last problem was evident in those areas we visited where State health agencies were not the title X grantee. For example:

--In the District of Columbia, HHS awarded title X family planning funds to three private organizations, bypassing Department of Human Resources officials who said that this situation impairs their ability to coordinate family planning efforts. No organization was responsible for assessing the need for and availability of such services districtwide and for coordinating and evaluating the delivery of such services.

--In Missouri, the State Health Department administers family planning funds under the MCH program but has no responsibility for title X project grants, which are made by HHS. According to an HHS region VII consultant, personnel at the regional office responsible for the MCH and family planning programs had not coordinated their efforts in the State. In addition, the executive director of a nonprofit organization receiving title X funds in Kansas City, Missouri, told us that there has been little coordination among family planning providers in that city.

HHS officials acknowledged that its project grants to private organizations have hampered the States' ability to plan and coordinate family planning activities. They said that they had expected the State MCH programs to take the lead coordinating role, but that this generally did not happen. Thus, HHS was working to resolve the problem.

Family planning programs often do not focus on high-risk women

Family planning programs have been increasing their emphasis on serving adolescents; moreover, HHS has instructed them to give special attention to those women, who because of their age, are considered high risk. However, many family planning programs do not assign special

priority goals for serving women considered high risk for reasons other than age.

For example, California's Office for Family Planning and the Virginia and North Carolina title X programs (administered by the State health departments) had no specific objectives for serving high-risk women, nor did they monitor the extent to which they served such groups. Virginia's family planning goal was to serve 75 percent of the State's medically indigent women over a 3-year period. In North Carolina, the State's Improved Child Health program (a special initiative sponsored by HHS to reduce infant mortality) developed a specific objective for reducing the number of pregnancies in two counties considered high-risk areas because of lack of maternal education, previous adverse pregnancy outcome, Rh complications, and age. Yet a North Carolina official told us that family planning programs generally gave no priority to improving pregnancy outcome, nor was this a factor in allocating funds to local county health departments.

Family planning grantees do not focus on high-risk women between ages 18 and 34 for several reasons; authorizing laws do not require it, some administrators do not consider it to be an appropriate goal for such programs, and limited funds often preclude major outreach efforts.

Preventing adolescent pregnancies requires more special efforts

We, HHS, and others have identified several obstacles that either impede adolescents' access to family planning services or hamper their effective use. HHS can--and in some cases has already begun to--address some of these problems by taking more aggressive and coordinated actions concerning adolescent pregnancy. HHS has provided additional resources to expand or improve the availability of family planning services and to link various programs, but this has not been enough. Persistent problems include:

--Restrictive State laws. Several States do not specifically allow minors to receive birth control services without parental consent.

--Lack of a focal point or coordinator/monitor. In the areas we visited, it appeared that no one had clear responsibility for combining efforts to prevent adolescent pregnancy. This problem acutely affects adolescents because their schools usually were not involved with health care and family planning programs.

--Lack of motivation, fear, or negative attitudes. Many adolescents have psychological barriers that prevent them from seeking or effectively using family planning services. Many teens do not seek family planning services because they are afraid of the medical examination or loss of confidentiality.

--Limited outreach. Outreach and followup aimed directly at adolescents (and other high-risk patients) are frequently limited and sometimes nonexistent, often because of insufficient funding. For example, according to the outreach coordinator, the Virginia Family Planning Bureau evaluated 24 family planning clinics during 1977, and about half of these clinics were using outreach workers in clinical services rather than outreach.

ENSURE HIGH QUALITY PERINATAL CARE

I would like now to discuss some of the problems identified in our review of obstetrical practices.

How babies are delivered is an important national concern. Each year more than 3 million deliveries occur in the United States. Obstetric practices used during these births may improve the chances for mother and baby

to come through the birth process healthy. However, these same practices may contribute to perinatal mortality, birth injury, or permanent injury to the child, and may contribute to injury to the mother.

The Federal Government, through HHS, attempts to ensure the safety and efficacy of drugs and medical devices, funds medical research and Professional Standards Review Organizations which evaluate medical practices, educates the public on health care, and pays for deliveries under some programs.

We found that current Federal efforts in these areas of responsibility needed improvement.

--The Food and Drug Administration (FDA) is responsible for regulating drugs and medical devices under the Food, Drug, and Cosmetic Act of 1938, as amended. One of FDA's major responsibilities is to approve new drugs before marketing. FDA's approval process for new drugs is based on animal studies and clinical studies on a limited number of humans. FDA does not have the opportunity to observe long-term effects of obstetric drugs on infants until drugs are marketed and used extensively. Also, FDA does not require

regular reviews of marketed drugs, and its present system for monitoring marketed drugs does not ensure that it knows about all adverse reactions. Thus, there is no assurance that action will be promptly taken when needed to remove drugs from the market or add label warnings when adverse effects are identified.

--Federal funding of research on the obstetric practices we reviewed has been fragmented and lacks overall direction. Generally, the research literature we reviewed was inconclusive on the benefits and risks of obstetric practices and did not address the effects of obstetric practices on the child beyond the first day of life. Also, most of the research was retrospective, dealt solely with one hospital's experience with a particular practice, and did not have matching control groups.

--Medical care evaluation studies of obstetrical practices by Professional Standards Review Organizations have been infrequent because, according to HHS, these organizations and

hospitals have given higher priority to the medical and surgical areas which involve larger numbers of patients. In a number of cases, the research literature we reviewed identified situations in which incorrect use of obstetric practices resulted in adverse pregnancy outcome. For example, researchers sometimes attributed premature births to incorrectly timed cesarean sections or inductions of labor. Aside from adversely affecting infants, such incorrectly timed procedures can increase the cost of childbirth substantially.

--HHS has given little emphasis to educating and informing the public on risks and benefits of obstetric procedures. Seeing that women are informed during the prenatal period about current knowledge of benefits and risks of obstetrical practices is important so that they can make informed decisions in conjunction with health care professionals about elective procedures during routine childbirth, such as elective induction of labor or use of anesthetics.

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Mr. Chairman, this concludes our statement. We would be pleased to answer any questions you or any other Members of the Subcommittee may have.

BRIEF DISCUSSION OF SELECTED ACTIONS NEEDED TO FURTHER REDUCE INFANT MORTALITY

EASE RESTRICTIONS ON NATIONAL HEALTH SERVICE CORPS PLACEMENTS TO STATE AND LOCAL GOVERNMENTS

In December 1978, HHS informed Regional Health Administrators of a new policy for placing Corps personnel. This policy provides, in part, that States, other than the original 13 which received MCH project grants to improve pregnancy outcome, would not be likely to receive a waiver of the requirement to reimburse the Federal Government for the full cost of providing Corps personnel. According to HHS staff, this policy will probably make it difficult for States, other than the 13, to use Corps personnel because they could not pay the full cost. For physicians and nurses who were Corps scholarship recipients, the cost during 1980 as determined by HHS is $39,000 and $26,000 annually, respectively.

According to HHS, this policy resulted from an Office of Management and Budget determination that HHS not grant waivers of reimbursement for the costs of Corps personnel assigned to carry out traditional State functions. However, Public Law 94-484 requires HHS, in approving applications for Corps personnel, to give priority to areas or organizations--public or private--proposing to serve

areas in greatest need, giving special consideration to specified indicators, including infant mortality. The act also authorizes HHS to waive requirements for reimbursing the Government for the costs of Corps personnel if the organization is financially unable to meet such requirements, if compliance would unreasonably limit the ability to provide adequate support for the provision of health services by Corps members, or if a significant percentage of persons in the service area live in poverty or have other characteristics which indicate an inability to pay for services. According to HHS, the bulk of the organizations having Corps personnel receive full or partial reimbursement waivers.

We believe that a critical factor to consider in making a decision to grant a cost waiver should be the characteristics of the population to be served rather than the organization to which Corps personnel are attached. Therefore, we believe that the Congress should clarify section 334 of the Public Health Service Act to specifically include State and local governments among those eligible for cost reimbursement waivers for Corps personnel who will provide new or additional services to needy persons.

EXPAND USE OF
NURSE-MIDWIVES

Many pregnant women receive prenatal care late or not at all. HHS, health professionals, and private organizations, such as the American Academy of Pediatrics and the National Foundation-March of Dimes, believe that prenatal care is one of the most critical health services for improving pregnancy outcome. In fact, State MCH directors told us that expanding or improving prenatal care services was their highest priority for improving pregnancy outcome.

In addition to the problems previously noted concerning Medicaid, many women have difficulty gaining access to prenatal or other care because (1) many areas lack obstetricians or other trained health care professionals; (2) many general practitioners do not provide obstetrical care, reportedly because of rising malpractice insurance costs or limited obstetrical training; and (3) many obstetricians are decreasing or discontinuing their obstetrical services and switching to gynecology because of malpractice insurance costs or other reasons. Nurse-midwives, who are specially trained to provide maternity services for uncomplicated pregnancies, could help fill the gaps created by these problems. However, they are in short supply and are discouraged or restricted from practicing in many areas. Also, it appears less costly to use nurse-midwives, who work in conjunction with physicians, than to rely on physicians alone.

FACILITATE REGIONALIZATION OF PERINATAL CARE

Regionalized perinatal care is designed to assure ready access to and efficient use of labor, delivery, and infant intensive care services by better organizing and using medical knowledge, techniques, and resources to achieve a network of perinatal care services in a specified area or community. It entails the development of (1) a graded system of facilities for handling various categories of mothers and infants, (2) systems for screening pregnant women to identify risk factors, referring, and transporting mother and/or infant to the appropriate facility, (3) communication among providers, (4) data collection and followup systems, and (5) programs for training and educating personnel.

The Federal Government, through such programs as Hill-Burton Hospital Construction, MCH, and Medicaid, has helped develop or pay for care units, thereby helping many persons gain access to them. Furthermore, the Government has promoted and even required the development of regionalized, efficient systems of care for mothers and newborns. Nevertheless, people in some locations still do not have easy access to appropriate labor and delivery services or infant intensive care units. Many areas do not have regionalized efficient systems of perinatal care, although progress has been made.

None of the States visited had achieved a regionalization of perinatal care that provides comprehensive services in all parts of the State, although regionalization efforts were underway in one or more areas of each State. States generally had made more progress in beginning or establishing regionalized systems of care for inpatient hospital or infant intensive care services than for such services as prenatal or well baby care.

Neither HHS nor private organizations, such as the National Foundation-March of Dimes or the American College of Obstetricians and Gynecologists, we contacted could provide us with national information on the status of implementing regionalized perinatal care. Although HHS' regulations for the MCH program require that a State's program of projects for infant intensive care will be evaluated as to its progress in developing regionalized perinatal care, HHS' MCH officials had not systematically monitored State efforts and progress in this area. HHS's Health Resources Administration had contracted for a study to obtain some information on regionalization status, but was working independently of the Department's MCH program officials.

Several factors contribute to the uneven progress that has been made, and difficult problems that persist. These include but are not limited to:

--The lack of or geographic maldistribution of physicians or facilities.

--Physician or hospital resistance to closing underused obstetrical units.

--The high cost of in-hospital obstetric and newborn care, particularly infant intensive care.

-- The inability of many to afford the cost of this care and the failure of some insurance programs, including Medicaid, to always cover the full cost.

--The refusal of some physicians or hospitals to accept Medicaid or low-income patients or to refer patients to others.

--The lack of a comprehensive system for efficiently providing in-hospital maternity and infant care and the existence of dual private and public sector "systems" of care in many communities.

Examples follow:

The University of Southern California Medical Center delivered about 14,000 babies in 1976--about one-fourth

of all those delivered in Los Angeles that year--in a facility designed to deliver 9,000 babies annually. The hospital's infant intensive care unit caseload indicated it should have 12 beds, but it had only 4 to 6 based on the availability of nurses, and the mortality rate for infants born at the hospital was increasing. The Medical Center was serving a large number of low-income undocumented aliens who were ineligible for Medicaid, Medicaid patients who could not deliver at private hospitals because of low Medicaid payment rates (even though obstetrical bed capacity was available), and poor patients from some rural counties with no public hospital. The infant intensive care unit at another Los Angeles County facility--Martin Luther King Memorial Hospital--was experiencing similar problems and could not accept referrals of infants born at other hospitals, as envisioned in the area's regionalization plan.

In 1977, the Halifax County, North Carolina, maternity and infant care project approved 91 of the 127 deliveries by untrained midwives in the county that year because the local hospital would generally not accept pregnant patients for delivery who could not pay. The project could only pay hospital costs for high-risk cases. Similarly, a Corps obstetrician in another rural North Carolina area

had to approve some of her prenatal care patients for delivery by untrained midwives at home because they could not afford the hospital cost, and the hospital would not accept patients who could not pay.

An official at one Missouri hospital we contacted said that the hospital will not admit women for delivery who cannot pay a $400 deposit. A representative from another Missouri hospital said that nonemergency obstetric patients who do not have insurance or who cannot pay will not be admitted unless they are considered of "teaching value." Those who cannot pay or who are not of "teaching value" are referred to the city hospital.

HHS needs to take more aggressive action to help resolve many of these problems. For example, it should urge or require State MCH agencies, health planning agencies, and State Medicaid agencies to work together along with the private medical community and other appropriate groups to hasten efforts to develop and implement systematic approaches to in-hospital care of mothers and newborns, such as regionalized care.

EXPAND EFFORTS TO EDUCATE THE PUBLIC

Many women do not promptly seek prenatal care for themselves, well baby care for their infants, or family planning services because they lack motivation to do so

or are not convinced of their importance. Unmarried mothers, particularly teenagers, frequently delay seeking prenatal care because they deny that they are pregnant or they want to delay confirming their pregnancy. Providing additional public education on the value and importance of preventing or favorably timing high-risk pregnancies, seeking prenatal care early during pregnancy, and seeking periodic well baby care for infants is regarded by many health professionals as an important activity for making further improvements in pregnancy outcome. Accordingly, we believe that the Federal Government should launch, in conjunction with other organizations, a major nationwide information and education campaign to improve public awareness and stimulate action.

Comprehensive data are not available to demonstrate the effectiveness of education on the prevention of teenage pregnancy. Nevertheless, many health and education professionals and parents believe that teaching youngsters about family life, including sex education, is critical to pregnancy prevention and health promotion. Although few seem to disagree with this belief, much controversy exists over who should provide this education, what information should be taught, when and to whom it should be provided, and how it should be provided. Until this controversy is resolved, it appears that progress will be slow.

RECENT GAO REPORTS RELATING TO IMPROVED PREGNANCY OUTCOME

"Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," (HRD-80-24, Jan. 21, 1980).

"Evaluating Benefits and Risks of Obstetric Practices--More Coordinated Federal and Private Efforts Needed," (HRD-79-85, Sept. 24, 1979).

"A Review of Research Literature and Federal Involvement Relating to Obstetric Practices," (HRD-79-85A, Sept. 24, 1979).

Letter Report to the Director, Department of Human Resources, Government of the District of Columbia, on infant mortality problems in the District (Oct. 31, 1978).

"The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better," (CED-79-55, Feb. 27, 1979).

"Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families," (HRD-79-40, Feb. 6, 1979).

"Preventing Mental Retardation--More Can Be Done," (HRD-77-37, Oct. 3, 1977).

"How Developmental Disabilities Programs Are Working," (HRD-80-43, Feb. 20, 1980).